EPI-2
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Dengue, Chikungunya and Zika Reporting Form

US Virgin Islands Department of Health, Epidemiology Division
Phone: (340) 718-1311 Ext. 3841 Fax: (340) 718-1508

Form is published at
http://doh.vi.gov/forms

Case Number / SAN ID / GCODE	Specimen #	Days Post Onset (DPO)	Type	Date Received	Specimen #	Days Post Onset (DPO)	Type	Date Received
	S1				S3			
	S2				S4			

PLEASE READ AND COMPLETE ALL SECTIONS *especially those marked with an asterisk*

***Select suspected disease*:** ☐ Dengue ☐ Chikungunya ☐ Zika

Today's Date: _____ (mm/dd/yyyy)

Island: ☐ St. Croix ☐ St. John ☐ St. Thomas ☐ Water Island

Patient Data

***Hospitalized due to this illness?** ☐ No ☐ Yes → If yes, hospital name: Record Number:

Patient Name (Last)	**(First)**	**(MI)**	**Fatal?** ☐ Yes ☐ No ☐ Unk
Parent/Guardian (if applicable):			**Mental Status Change?** ☐ Yes ☐ No ☐ Unk

Home, Physical Address (indicate ESTATE)

Residence is close to:

City Zip Code

***Telephone:** Other Tel:

Physician Who Referred This Case

***Physician Name:**

***Physician Address:**

***Physician Phone:** ***Fax:**

***Email:**

Work Address:

Patient's Demographic Information

***Date of Birth** (mm/dd/yyyy)

Age (months or years) _____ months _____ years

Gender: ☐ Male ☐ Female

Pregnant? ☐ Yes ☐ No ☐ Unk Weeks pregnant (gestation):

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ Black ☐ White ☐ Asian ☐ Unknown ☐ Other:

Who filled out this form?

Name (complete): Relationship with patient:

Telephone: Fax: Email:

Must Have the Following Information for Sample Processing

***Date of first symptom** (mm/dd/yyyy)

***Date specimen taken**

First sample (mm/dd/yyyy)

Second sample (mm/dd/yyyy)

How long have you lived in this city? _____ **Country of Birth:** _____

During the 14 days before onset of illness, did you TRAVEL to other cities or countries?

☐ Yes, another country ☐ Yes, another city ☐ No ☐ Unk

Where did you travel?

Are there any sick contacts in your household? ☐ Yes ☐ No

PLEASE indicate below the signs and symptoms that the patient had at the time of illness

	Yes	No	Unk
Fever lasting 2-7 days			
*Fever (>38°C/101°F)			
Platelets ≤100,000/mm3			
Platelets Count _____			
Any Hemorrhagic Manifestation			
Petechiae			
Purpura/Ecchymosis			
Vomit with blood			
Blood in stool			
Nasal bleeding			
Bleeding gums			
Blood in urine			
Vaginal bleeding			
Positiveurinalysis (over 5 RBC/hpf or positive for blood)			

Tourniquest Test ☐ Positive ☐ Negative ☐ Not done

Evidence of Capillary Leak

Lowest Hematocrit _____ (%)

Highest Hematocrit _____ (%)

Lowest Serum Albumin _____

Lowest Serum Protein _____

Lowest Blood Pressure (SBP/DBP) _____/_____

Lowest Pulse Pressure (systolic-diastolic) _____

Lowest white blood cell count (WBC) _____

Symptoms	Yes	No	Unk
Rapid, weak pulse			
Pallor or cool skin			
Chills			
Rash			
Headache			
Eye pain			
Body (muscle/bone) pain			
*Joint pain			
Anorexia			

Warning Signs	Yes	No	Unk
Persistent vomiting			
Abdominal pain/tenderness			
*Mucosal bleeding			
Lethargy, restlessness			
Liver enlargement >2cm			
Pleural or abdominal effusion			
Additional Symptoms			
Diarrhea			
Cough			
Conjunctivitis			
Nasal congestion			
Sore throat			
Jaundice			
Convulsion or coma			
Nausea and vomiting (occasional)			
*Arthritis (swollen joints)			
*Missed school/work due to this illness			
*Unable to walk during this illness			